MUTUAL of OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175, 402 342 7600

MEDICARE SUPPLEMENT INSURANCE POLICY

PLAN F

CONSIDERATION

In consideration of the first premium you paid, the application you completed and our reliance on your answers to the application questions, we have put this policy in force as of the Policy Date. That date is shown on the policy schedule. A copy of your application is attached.

30-DAY RIGHT TO EXAMINE POLICY

Please read your policy. If, for any reason, you are not satisfied with it, you may return your policy to us or your agent within 30 days of its delivery. We will then promptly refund all premiums paid less any claims paid. The policy will then be considered never to have been issued.

PLEASE READ YOUR APPLICATION

Please read the attached copy of your application immediately. If anything is not correct or if any past medical history has been left out, you should tell us. Your policy was issued on the basis that all information in the application is correct and complete. If not, your policy may not be valid.

GUARANTEED RENEWABLE FOR LIFE

This policy is guaranteed renewable for life. This means you have the right to continue your policy in force for as long as you live. Unless there has been a Material Misrepresentation, we cannot cancel your coverage as long as you pay the required premium payment when it is due.

PREMIUM CHANGES

The premium for this policy will change. Because the premium rate is based upon your attained age, the premium will increase each year as you age, until you reach Age 80. This annual change will occur on the first Policy Renewal Date which coincides with or follows the policy anniversary date.

The premium may also change for reasons other than attained age. This type of premium change can occur on any Policy Renewal Date. However, such premium change cannot be made unless we make the same change to all policies of this form issued to persons of the same classification living in the same geographic area of your state. We will give you the advance written notice required by your state prior to any premium change.

This Is a Legal Contract Between You and Us.
READ YOUR POLICY CAREFULLY.
NOTICE TO BUYER:
THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
To Inquire About Your Coverage, or To Express a Concern, Call Us Toll-Free At:
Customer Service *[1-877-845-0892]*
Claims Service *[1-877-617-5587]*

Daniel P. Neary — **Chairman of the Board**

Michael Fuss — **Corporate Secretary**

TABLE OF CONTENTS PAGE

DEFINITIONS

Shown below are the defined terms used in your policy. These terms are capitalized wherever they appear in the policy.

Accept(s) Assignment means a Physician or provider of medical services receives payment directly from Medicare Part B and agrees to charge no more for services performed than the amount approved by Medicare. When a Physician or provider accepts assignment, he or she will not bill you for the excess charge difference between the actual charge and the amount approved by Medicare.

Age 80 means the first Policy Renewal Date following the policy anniversary date which coincides with or next follows your 80th birthday.

Benefit Period means the period of time defined by Medicare as a benefit period under Medicare Part A. A benefit period begins on the first day you are Hospital confined as an inpatient. A benefit period generally ends after you have not been confined in a Hospital or skilled nursing facility for 60 days in a row.

Emergency Care means care needed immediately because of a Sickness or Injury of sudden and unexpected onset.

Hospital means a place defined as a hospital and approved for payment as a hospital by Medicare.

Injury means bodily harm sustained by you which:

(a) is the direct result of an accident or trauma that occurs while your policy is in force; and
(b) is not related to Sickness, bodily infirmity or any other cause.

Material Misrepresentation means a condition or combination of conditions you were requested to disclose on the application were not disclosed and which, if disclosed, would have required a different premium or caused us to deny issuing your policy. Any material misrepresentation is subject to the Time Limit on Certain Defenses provision.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. Traditional Medicare is divided into two parts, Part A (Hospital/skilled nursing facility coverage) and Part B (medical/surgical coverage).

Medicare Eligible Expenses mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Physician means a physician as defined by Medicare.

Policy Date means the date coverage starts under this policy as shown on the policy schedule.

Policy Renewal Date means the month and day this policy's premium payment is due. The frequency of the policy renewal date can vary depending on whether the premiums are paid on a monthly, quarterly, semiannual, or annual basis.

Sickness means an illness, disease or physical condition incurred by you which causes loss beginning while your policy is in force.

We, Us or Our means Mutual of Omaha Insurance Company.

You or Your means the person named as the Insured on the policy schedule.

BASIC CORE BENEFITS

Your Medicare Supplement Insurance Policy is designed to coordinate with benefits provided by the federal Medicare program. We will consider our benefits:

(a) as if you are enrolled in both Part A and Part B of Medicare (even if you are not enrolled in Part B); and
(b) as if Medicare has paid its portion of the expense incurred.

When you receive services for Medicare Eligible Expenses, we will pay basic core benefits as follows:

Inpatient Hospital Confinement Benefits (Medicare Part A)

Coinsurance Benefit: We will pay the Part A Medicare coinsurance amount for each day of inpatient Hospital confinement you incur from the 61st day through the 90th day in each Medicare Benefit Period to the extent not covered by Medicare.

Lifetime Reserve Days Benefit: We will pay the Part A Medicare coinsurance amount for each lifetime reserve day of inpatient Hospital confinement you incur to the extent not covered by Medicare. Lifetime reserve days are nonrenewable and limited to 60 days during your lifetime.

Medicare Exhaustion Benefit: After all Medicare inpatient Hospital confinement benefits are exhausted, including your lifetime reserve days, we will pay 100% of the Part A Medicare Eligible Expenses you incur for inpatient Hospital confinement. Benefits are payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted. Medicare exhaustion benefits are limited to a maximum of 365 days of inpatient Hospital confinement payable during your lifetime.

Blood Deductible Benefit (Medicare Part A or Part B)

We will pay the expense incurred for the reasonable cost of the first three pints of unreplaced blood (or equivalent quantities of packed red blood cells) per calendar year under Medicare Part A or Part B. Once this three-pint calendar year blood deductible is met under either Part A or Part B of Medicare, it does not have to be met under the other Part. You or someone else may donate blood to replace the blood you use, in accordance with federal regulations.

Medicare Part B Coinsurance Benefit

After the Medicare Part B calendar year deductible has been satisfied, we will pay the coinsurance amount not paid by Medicare applicable to Part B Medicare Eligible Expenses. The coinsurance amount is generally 20% of the total amount approved by Medicare for medical services. In the case of Hospital outpatient department services under a prospective payment system, we will pay the co-payment amount.

Hospice Care Benefit

We will pay the copayment/coinsurance amount for all Part A Medicare eligible hospice care and respite care expenses.

PLAN F ADDITIONAL BENEFITS

When you receive services for Medicare Eligible Expenses, we will pay additional benefits applicable to Plan F as follows. Plan F Additional Benefits are subject to the same terms and conditions as Basic Core Benefits.

Inpatient Hospital Confinement Deductible Benefit (Medicare Part A)

When you are confined in a Hospital as an inpatient, we will pay 100% of the Medicare Part A inpatient Hospital deductible amount due for each Benefit Period.

Skilled Nursing Facility Confinement Benefit (Medicare Part A)

When you are confined in a skilled nursing facility for post-Hospital care eligible under Medicare Part A, we will pay the actual billed charges, up to the daily coinsurance amount, for each day of confinement from the 21st day through the 100th day, during each Medicare Benefit Period.

Medicare Part B Deductible Benefit

We will pay 100% of the Medicare Part B deductible amount due each calendar year for Part B Medicare Eligible Expenses incurred.

Medicare Part B Excess Charges Benefit

We will pay 100% of the difference between the actual charge billed to Medicare Part B for medical expenses incurred and the amount approved by Medicare Part B. When a provider of medical services Accepts Assignment, no excess charges will be payable by us. When a provider of medical services does not Accept Assignment, the amount of excess charge difference we will consider cannot exceed any charge limitation established by the Medicare program or state law.

Emergency Care in a Foreign Country Benefit

If you receive Emergency Care while in a foreign country, we will pay 80% of the billed Medicare Eligible Expenses incurred for Hospital, Physician and medical services to the extent such expenses are not covered by Medicare, after a $250 calendar year deductible has been satisfied by you. Benefits are payable only for Emergency Care that would have been covered by Medicare to the extent such Emergency Care would have been covered by Medicare if provided in the United States. Benefits are limited to:

(a) Emergency Care which begins during the first 60 days in a row of each trip you make outside of the United States; and
(b) a maximum payable of $50,000 during your lifetime.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

If Medicare changes any of its deductible amounts or coinsurance percentage amounts, your policy's benefits will automatically adjust to coordinate with such changes. Your policy's premium may also adjust to correspond with these benefit changes. Likewise, if Medicare changes the period of time or number of days applicable to a particular benefit, your policy will adjust accordingly.

EXTENSION OF BENEFITS

If you incur expense for a continuous loss which began while this policy was in force, coverage for such loss will continue beyond the date insurance ends. This extension of coverage is:

(a) subject to your continuous total disability; and
(b) limited to the duration of the Medicare Benefit Period or, if none is applicable, payment of the maximum benefits.

Benefits are payable during this extension on the same basis as if coverage had not ended. However, coverage is extended only for those covered Sicknesses or Injuries causing the continuous loss. Receipt of Medicare Part D outpatient prescription drug benefits will not be considered in determining a continuous loss.

SUSPENSION OF COVERAGE

Suspension Available During Medicaid Entitlement

If you apply for and become entitled to medical assistance under Medicaid, we will suspend benefits and premiums under this policy at your request, as long as you notify us within 90 days after the onset of Medicaid entitlement. This suspension of coverage can last for up to 24 months while your Medicaid entitlement continues.

Upon our receipt of your timely notification, we will refund any unearned premium for the period of time you are eligible for Medicaid. Your refunded premium will be reduced by the amount of any claims paid for the period you are eligible.

If you lose entitlement to Medicaid benefits during this suspension of coverage, your policy will be automatically reinstituted as long as you notify us of the loss of entitlement within 90 days after it occurs. Automatic reinstitution of coverage will be effective as of the date of Medicaid termination. You must pay the applicable policy premium. Upon reinstitution, we will:

(a) provide coverage substantially equivalent to the coverage in effect prior to the date of suspension; and
(b) charge a premium at least as favorable as if coverage had not been suspended.

Suspension Available While Covered Under a Group Health Plan

If you are entitled to benefits under Section 226(b) of the Social Security Act and covered under a group health plan, we will suspend benefits and premiums under this policy at your request. This suspension of coverage can last as long as the period provided by federal regulation.

Upon our receipt of your timely notification, we will refund any unearned premium for the period of time you are covered under the group health plan. Your refunded premium will be reduced by the amount of any claims paid for the period you are eligible.

If you lose coverage under the group health plan during this suspension of coverage, your policy will be automatically reinstituted as long as you notify us of such loss of coverage within 90 days after it occurs. Automatic reinstitution of your policy's coverage will be effective as of the date of group health plan termination. You must pay the applicable policy premium. Upon reinstitution, we will:

(a) provide coverage substantially equivalent to the coverage in effect prior to the date of suspension; and
(b) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

This policy will terminate on the earliest of:

(a) the date we receive your written or verbal request to cancel the policy (in which case the grace period will not apply);
(b) the date this policy is replaced by another Medicare supplement or Medicare Select policy (in which case the grace period will not apply);

(c) the Policy Renewal Date, if sufficient premium has not been paid before the end of the grace period; or
(d) the date of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

Termination of coverage will not affect any claim originating while this policy was in force.

EXCLUSIONS

We will not pay benefits for:

(a) expense incurred while this policy is not in force, except as provided in the Extension of Benefits section;
(b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
(c) that portion of any expense incurred which is paid for by Medicare;
(d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
(e) services for which a charge is not normally made in the absence of insurance; or
(f) loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

CLAIMS FILING PROCEDURES

Notice of Claim

Written notice of a claim must be given to us within 20 days after a loss occurs or starts, or as soon as is reasonably possible. You may give the required notice or someone else may do it for you. The notice should give your name and policy number as shown on the policy schedule. Notice should be mailed to us in Omaha, Nebraska, or to any of our agents.

Electronic Claim Filing Process: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, a paper copy of your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us or your health care provider may submit it to us on your behalf.

Claim Forms

When we receive notice of claim, we will send you, within 10 working days, forms for filing proof of loss. If we do not send them within 10 days after the giving of such notice, you can meet the proof of loss requirement by giving us a written statement of what happened. We must receive this statement within the time given for filing proof of loss.

Proof of Loss

Written proof of loss must be given to us within 90 days after the date of such loss. If it was not reasonably possible to give us written proof within the required time, we will not reduce or deny the

claim for this reason if the proof is supplied as soon as reasonably possible. In any case, proof must be furnished no later than 12 months from the time otherwise specified, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS

Benefits for a covered loss will be paid or denied within 30 days after receipt of written proof of loss. If we fail to pay benefits or deny a claim, we will provide a written notice within 30 days of receiving proof of loss. If we do not provide such notice, the claim is assumed to be a clean claim and will be paid within 30 days after our receipt of the proof of loss. If we provide such notice and request specific information that is needed to process the claim, we will pay the claim no later than 15 calendar days after our receipt of the specific information. A claim is considered paid on the day the payment is mailed or transmitted electronically.

If we fail to provide notice of denial within the 30 days of receiving proof of loss, interest will be paid at a rate of 15% annually beginning on the 31st day after receipt of proof of loss and to the date the late payment is made. However, interest amounting to less than $1.00 will not be paid.

PAYMENT OF CLAIMS

All benefits will be paid to you, if living, unless we receive an assignment of benefits by you to pay your health care provider. Benefits unpaid at your death, which are not assigned, will be paid to your estate.

If any benefits are payable to your estate, to a minor or to any person not legally able to give a valid release, we may pay up to $1,000 to any relative of yours who we find entitled to the payment. Payment made in good faith will fully discharge us to the extent of the payment.

TERM OF COVERAGE

Your coverage starts on the Policy Date at 12:01 A.M. where you live. It ends at 12:01 A.M. where you live on the first Policy Renewal Date. Each time you renew your policy by paying the premium within the 31-day grace period, the new term begins when the old term ends.

POLICY PROVISIONS

Entire Contract and Changes

The entire contract of insurance is:

(a) the policy;
(b) the attached signed application;
(c) any supplemental applications made part of the policy;
(d) any riders and amendment riders; and
(e) any endorsements and amendments.

No agent may change the contract of insurance in any way. Only an executive officer of ours can approve a change. Any such change must be shown in or attached to the policy. Any rider, endorsement or application added after the Policy Date which reduces or eliminates coverage under this policy will require your signed acceptance in order to be valid.

Time Limit on Certain Defenses

After two years from the date you become covered under this policy, we cannot use misstatements, except fraudulent misstatements in your application, to void coverage or deny a claim for loss incurred or disability that starts after the two-year period.

Grace Period

Your policy's premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during the grace period.

Reinstatement

Your policy will lapse if you do not pay the premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement, this policy will be put back in force when we approve the application. If we do not approve the application, this policy will be put back in force on the 45th day following the date of the application if we do not give you prior written notice of its disapproval.

The reinstated policy will only cover loss due to an Injury or Sickness that occurs after the date of reinstatement. In all other respects, you and we have the same rights under this policy as were in effect before it lapsed. Premium accepted in connection with this provision will be used for a period for which premium has not been paid, but not for any period more than 60 days before the date of reinstatement.

Physical Examinations and Autopsy

We, at our expense, may have you examined when and as often as is reasonable while a claim is pending. We may also have an autopsy done, at our expense, where it is not prohibited by law.

Legal Actions

No legal action can be brought to recover under this policy until at least 60 days after we have been given satisfactory written proof of loss. Legal action cannot be brought after the expiration of three years from the date proof of loss is required.

Other Insurance with Us

You can be insured under only one of our Medicare supplement policies at any one time. If you are insured under more than one such policy, you can select the one that is to remain in effect. In the event of death, this selection will be made by your estate. We will return all premiums paid (less any claims paid) for any policy that does not remain in effect.

Unpaid Premium

When benefits are paid for a claim under this policy, any premium then due and unpaid may be deducted from the benefits payable.

Conformity with State Statutes

If any provision of this policy conflicts with the laws of the state where you reside on that provision's effective date, it is amended to conform to the minimum requirements of those laws.